Z-0441.4

HOUSE BILL 1633

State of Washington 57th Legislature 2001 Regular Session

By Representatives Campbell and Cody; by request of Insurance Commissioner

Read first time 01/31/2001. Referred to Committee on Health Care.

1 AN ACT Relating to technical corrections to chapters 79 and 80,
2 Laws of 2000; and amending RCW 48.20.025, 48.41.030, 48.41.100,
3 48.41.110, 48.43.005, 48.43.012, 48.43.015, 48.43.018, 48.43.025,
4 48.44.017, 48.46.062, and 70.47.060.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 **Sec. 1.** RCW 48.20.025 and 2000 c 79 s 3 are each amended to read
7 as follows:
8 (1) The definitions in this subsection apply throughout this
9 section unless the context clearly requires otherwise.
10 (a) "Claims" means the cost to the insurer of health care
11 services, as defined in RCW 48.43.005, provided to a policyholder
12 or paid to or on behalf of the policyholder in accordance with the
13 terms of a health benefit plan, as defined in RCW 48.43.005. This
14 includes capitation payments or other similar payments made to
15 providers for the purpose of paying for health care services for a
16 policyholder.
17 (b) "Claims reserves" means: (i) The liability for claims which

have been reported but not paid; (ii) the liability for claims which have not been reported but which may reasonably be expected; (iii) active life reserves; and (iv) additional claims reserves whether for a specific liability purpose or not.

(c) "Earned premiums" means premiums, as defined in RCW 48.43.005, plus any rate credits or recoupments less any refunds, for the applicable period, whether received before, during, or after the applicable period.

(d) "Incurred claims expense" means claims paid during the applicable period plus any increase, or less any decrease, in the claims reserves.

(e) "Loss ratio" means incurred claims expense as a percentage of earned premiums.

(f) "Reserves" means: (i) Active life reserves; and (ii) additional reserves whether for a specific liability purpose or not.

(2) An insurer shall file, for informational purposes only, a notice of its schedule of rates for its individual health benefit plans with the commissioner prior to use.

(3) An insurer shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

(a) A description of the insurer's rate-making methodology;

(b) An actuarially determined estimate of incurred claims which includes the experience data, assumptions, and justifications of the insurer's projection;

(c) The percentage of premium attributable in aggregate for nonclaims expenses used to determine the adjusted community rates charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any insurer ((~~providing~~))

1 issuing or renewing individual health benefit plans in this state
2 during the preceding calendar year shall file for review by the
3 commissioner supporting documentation of its actual loss ratio for
4 its individual health benefit plans offered or renewed in the
5 state in aggregate for the preceding calendar year. The filing
6 shall include aggregate earned premiums, aggregate incurred
7 claims, and a certification by a member of the American academy of
8 actuaries, or other person approved by the commissioner, that the
9 actual loss ratio has been calculated in accordance with accepted
10 actuarial principles.

11 (a) At the expiration of a thirty-day period beginning with the
12 date the filing is ((~~delivered to~~)) received by the commissioner,
13 the filing shall be deemed approved unless prior thereto the
14 commissioner contests the calculation of the actual loss ratio.

15 (b) If the commissioner contests the calculation of the actual
16 loss ratio, the commissioner shall state in writing the grounds
17 for contesting the calculation to the insurer.

18 (c) Any dispute regarding the calculation of the actual loss
19 ratio shall, upon written demand of either the commissioner or the
20 insurer, be submitted to hearing under chapters 48.04 and 34.05
21 RCW.

22 (6) If the actual loss ratio for the preceding calendar year is
23 less than the loss ratio established in subsection (7) of this
24 section, a remittance is due and the following shall apply:

25 (a) The insurer shall calculate a percentage of premium to be
26 remitted to the Washington state health insurance pool by
27 subtracting the actual loss ratio for the preceding year from the
28 loss ratio established in subsection (7) of this section.

29 (b) The remittance to the Washington state health insurance
30 pool is the percentage calculated in (a) of ((~~the [this]~~)) this
31 subsection, multiplied by the premium earned from each enrollee in
32 the previous calendar year. Interest shall be added to the
33 remittance due at a five percent annual rate calculated from the
34 end of the calendar year for which the remittance is due to the
35 date the remittance is made.

36 (c) All remittances shall be aggregated and such amounts shall
37 be remitted to the Washington state high risk pool to be used as
38 directed by the pool board of directors.

1 (d) Any remittance required to be issued under this section
2 shall be issued within thirty days after the actual loss ratio is
3 deemed approved under subsection (5)(a) of this section or the
4 determination by an administrative law judge under subsection
5 (5)(c) of this section.
6 (7) The loss ratio applicable to this section shall be seventy-
7 four percent minus the premium tax rate applicable to the
8 insurer's individual health benefit plans under RCW 48.14.0201.

9 **Sec. 2.** RCW 48.41.030 and 2000 c 79 s 6 are each amended to read
10 as follows:
11 The definitions in this section apply throughout this chapter
12 unless the context clearly requires otherwise.
13 (1) "Accounting year" means a twelve-month period determined by
14 the board for purposes of record-keeping and accounting. The first
15 accounting year may be more or less than twelve months and, from
16 time to time in subsequent years, the board may order an
17 accounting year of other than twelve months as may be required for
18 orderly management and accounting of the pool.
19 (2) "Administrator" means the entity chosen by the board to
20 administer the pool under RCW 48.41.080.
21 (3) "Board" means the board of directors of the pool.
22 (4) "Commissioner" means the insurance commissioner.
23 (5) "Covered person" means any individual resident of this
24 state who is eligible to receive benefits from any member, or
25 other health plan.
26 (6) "Health care facility" has the same meaning as in RCW
27 70.38.025.
28 (7) "Health care provider" means any physician, facility, or
29 health care professional, who is licensed in Washington state and
30 entitled to reimbursement for health care services.
31 (8) "Health care services" means services for the purpose of
32 preventing, alleviating, curing, or healing human illness or
33 injury.
34 (9) "Health carrier" or "carrier" has the same meaning as in
35 RCW 48.43.005.
36 (10) "Health coverage" means any group or individual disability
37 insurance policy, health care service contract, and health

1 maintenance agreement, except those contracts entered into for the
2 provision of health care services pursuant to Title XVIII of the
3 Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not
4 include short-term care, long-term care, dental, vision, accident,
5 fixed indemnity, disability income contracts, ((~~civilian health~~
6 ~~and medical program for the uniform services (CHAMPUS), 10 U.S.C.~~
7 ~~55,~~)) limited benefit or credit insurance, coverage issued as a
8 supplement to liability insurance, insurance arising out of the
9 worker's compensation or similar law, automobile medical payment
10 insurance, or insurance under which benefits are payable with or
11 without regard to fault and which is statutorily required to be
12 contained in any liability insurance policy or equivalent self-
13 insurance.

14 (11) "Health plan" means any arrangement by which persons,
15 including dependents or spouses, covered or making application to
16 be covered under this pool, have access to hospital and medical
17 benefits or reimbursement including any group or individual
18 disability insurance policy; health care service contract; health
19 maintenance agreement; uninsured arrangements of group or group-
20 type contracts including employer self-insured, cost-plus, or
21 other benefit methodologies not involving insurance or not
22 governed by Title 48 RCW; coverage under group-type contracts
23 which are not available to the general public and can be obtained
24 only because of connection with a particular organization or
25 group; and coverage by medicare or other governmental benefits.
26 This term includes coverage through "health coverage" as defined
27 under this section, and specifically excludes those types of
28 programs excluded under the definition of "health coverage" in
29 subsection (10) of this section.

30 (12) "Medical assistance" means coverage under Title XIX of the
31 federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and
32 chapter 74.09 RCW.

33 (13) "Medicare" means coverage under Title XVIII of the Social
34 Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

35 (14) "Member" means any commercial insurer which provides
36 disability insurance or stop loss insurance, any health care
37 service contractor, and any health maintenance organization
38 licensed under Title 48 RCW. "Member" also means the Washington

1 state health care authority as issuer of the state uniform medical
2 plan. "Member" shall also mean, as soon as authorized by federal
3 law, employers and other entities, including a self-funding entity
4 and employee welfare benefit plans that provide health plan
5 benefits in this state on or after May 18, 1987. "Member" does not
6 include any insurer, health care service contractor, or health
7 maintenance organization whose products are exclusively dental
8 products or those products excluded from the definition of "health
9 coverage" set forth in subsection (10) of this section.
10 (15) "Network provider" means a health care provider who has
11 contracted in writing with the pool administrator or a health
12 carrier contracting with the pool administrator to offer pool
13 coverage to accept payment from and to look solely to the pool or
14 health carrier according to the terms of the pool health plans.
15 (16) "Plan of operation" means the pool, including articles, by-
16 laws, and operating rules, adopted by the board pursuant to RCW
17 48.41.050.
18 (17) "Point of service plan" means a benefit plan offered by
19 the pool under which a covered person may elect to receive covered
20 services from network providers, or nonnetwork providers at a
21 reduced rate of benefits.
22 (18) "Pool" means the Washington state health insurance pool as
23 created in RCW 48.41.040.

24 **Sec. 3.** RCW 48.41.100 and 2000 c 79 s 12 are each amended to read
25 as follows:
26 (1) The following persons who are residents of this state are
27 eligible for pool coverage:
28 (a) Any person who provides evidence of a carrier's decision
29 not to accept him or her for enrollment in an individual health
30 benefit plan as defined in RCW 48.43.005 based upon, and within
31 ninety days of the receipt of, the results of the standard health
32 questionnaire designated by the board and administered by health
33 carriers under RCW 48.43.018;
34 (b) Any person who continues to be eligible for pool coverage
35 based upon the results of the standard health questionnaire
36 designated by the board and administered by the pool administrator
37 pursuant to subsection (3) of this section;

(c) Any person who resides in a county of the state where no carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool; ((~~and~~))

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application; and

(e) Any medicare eligible person whose health insurance coverage, other than coverage under an individual or group health plan, is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums;

(b) Any person on whose behalf the pool has paid out one million dollars in benefits;

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs;

(d) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(d) of this section.

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county

1 where no carrier had been offering an individual health benefit
2 plan:
3 (a) If the health benefit plan offered is other than a
4 catastrophic health plan as defined in RCW 48.43.005, any person
5 enrolled in a pool plan pursuant to subsection (1)(c) of this
6 section in that county shall no longer be eligible for coverage
7 under that plan pursuant to subsection (1)(c) of this section, but
8 may continue to be eligible for pool coverage based upon the
9 results of the standard health questionnaire designated by the
10 board and administered by the pool administrator. The pool
11 administrator shall offer to administer the questionnaire to each
12 person no longer eligible for coverage under subsection (1)(c) of
13 this section within thirty days of determining that he or she is
14 no longer eligible;
15 (b) Losing eligibility for pool coverage under this subsection
16 (3) does not affect a person's eligibility for pool coverage under
17 subsection (1)(a), (b), or (d) of this section; and
18 (c) The pool administrator shall provide written notice to any
19 person who is no longer eligible for coverage under a pool plan
20 under this subsection (3) within thirty days of the
21 administrator's determination that the person is no longer
22 eligible. The notice shall: (i) Indicate that coverage under the
23 plan will cease ninety days from the date that the notice is
24 dated; (ii) describe any other coverage options, either in or
25 outside of the pool, available to the person; (iii) describe the
26 procedures for the administration of the standard health
27 questionnaire to determine the person's continued eligibility for
28 coverage under subsection (1)(b) of this section; and (iv)
29 describe the enrollment process for the available options outside
30 of the pool.

31 **Sec. 4.** RCW 48.41.110 and 2000 c 80 s 2 are each amended to read
32 as follows:
33 (1) The pool shall offer one or more care management plans of
34 coverage. Such plans may, but are not required to, include point of
35 service features that permit participants to receive in-network
36 benefits or out-of-network benefits subject to differential cost
37 shares. Covered persons enrolled in the pool on January 1, 2001,

may continue coverage under the pool plan in which they are enrolled on that date. However, the pool may incorporate managed care features into such existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance policy issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not otherwise limited or excluded. Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include, but not be limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

1 (d) Drugs and contraceptive devices requiring a prescription;
2 (e) Services of a skilled nursing facility, excluding custodial
3 and convalescent care, for not more than one hundred days in a
4 calendar year as prescribed by a physician;
5 (f) Services of a home health agency;
6 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
7 therapy;
8 (h) Oxygen;
9 (i) Anesthesia services;
10 (j) Prostheses, other than dental;
11 (k) Durable medical equipment which has no personal use in the
12 absence of the condition for which prescribed;
13 (l) Diagnostic x-rays and laboratory tests;
14 (m) Oral surgery limited to the following: Fractures of facial
15 bones; excisions of mandibular joints, lesions of the mouth, lip,
16 or tongue, tumors, or cysts excluding treatment for
17 temporomandibular joints; incision of accessory sinuses, mouth
18 salivary glands or ducts; dislocations of the jaw; plastic
19 reconstruction or repair of traumatic injuries occurring while
20 covered under the pool; and excision of impacted wisdom teeth;
21 (n) Maternity care services;
22 (o) Services of a physical therapist and services of a speech
23 therapist;
24 (p) Hospice services;
25 (q) Professional ambulance service to the nearest health care
26 facility qualified to treat the illness or injury; and
27 (r) Other medical equipment, services, or supplies required by
28 physician's orders and medically necessary and consistent with the
29 diagnosis, treatment, and condition.
30 (4) The board shall design and employ cost containment measures
31 and requirements such as, but not limited to, care coordination,
32 provider network limitations, preadmission certification, and
33 concurrent inpatient review which may make the pool more cost-
34 effective.
35 (5) The pool benefit policy may contain benefit limitations,
36 exceptions, and cost shares such as copayments, coinsurance, and
37 deductibles that are consistent with managed care products, except
38 that differential cost shares may be adopted by the board for

nonnetwork providers under point of service plans. The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(6) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection (7) of this section.

(7)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan ((~~in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan~~)). For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

1 (b) The pool shall waive any preexisting condition waiting
2 period for a person who is an eligible individual as defined in
3 section 2741(b) of the federal health insurance portability and
4 accountability act of 1996 (42 U.S.C. 300gg-41(b)).
5 (8) If an application is made for the pool policy as a result
6 of rejection by a carrier, then the date of application to the
7 carrier, rather than to the pool, should govern for purposes of
8 determining preexisting condition credit.

9 **Sec. 5.** RCW 48.43.005 and 2000 c 79 s 18 are each amended to read
10 as follows:
11 Unless otherwise specifically provided, the definitions in this
12 section apply throughout this chapter.
13 (1) "Adjusted community rate" means the rating method used to
14 establish the premium for health plans adjusted to reflect
15 actuarially demonstrated differences in utilization or cost
16 attributable to geographic region, age, family size, and use of
17 wellness activities.
18 (2) "Basic health plan" means the plan described under chapter
19 70.47 RCW, as revised from time to time.
20 (3) "Basic health plan model plan" means a health plan as
21 required in RCW 70.47.060(2)(d).
22 (4) "Basic health plan services" means that schedule of covered
23 health services, including the description of how those benefits
24 are to be administered, that are required to be delivered to an
25 enrollee under the basic health plan, as revised from time to
26 time.
27 ((~~(4)~~)) (5) "Catastrophic health plan" means:
28 (a) In the case of a contract, agreement, or policy covering a
29 single enrollee, a health benefit plan requiring a calendar year
30 deductible of, at a minimum, one thousand five hundred dollars and
31 an annual out-of-pocket expense required to be paid under the plan
32 (other than for premiums) for covered benefits of at least three
33 thousand dollars; and
34 (b) In the case of a contract, agreement, or policy covering
35 more than one enrollee, a health benefit plan requiring a calendar
36 year deductible of, at a minimum, three thousand dollars and an
37 annual out-of-pocket expense required to be paid under the plan

(other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

((~~(5)~~)) (6) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

((~~(6)~~)) (7) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(7)~~)) (8) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(8)~~)) (9) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(9)~~)) (10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

((~~(10)~~)) (11) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((~~(11)~~)) (12) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(12)~~)) (13) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(13)~~)) (14) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(14)~~)) (15) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision

1 or instrumentality of the state and such other facilities as
2 required by federal law and implementing regulations.

3 ((~~(15)~~)) (16) "Health care provider" or "provider" means:

4 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
5 practice health or health-related services or otherwise practicing
6 health care services in this state consistent with state law; or

7 (b) An employee or agent of a person described in (a) of this
8 subsection, acting in the course and scope of his or her
9 employment.

10 ((~~(16)~~)) (17) "Health care service" means that service offered
11 or provided by health care facilities and health care providers
12 relating to the prevention, cure, or treatment of illness, injury,
13 or disease.

14 ((~~(17)~~)) (18) "Health carrier" or "carrier" means a disability
15 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
16 service contractor as defined in RCW 48.44.010, or a health
17 maintenance organization as defined in RCW 48.46.020.

18 ((~~(18)~~)) (19) "Health plan" or "health benefit plan" means any
19 policy, contract, or agreement offered by a health carrier to
20 provide, arrange, reimburse, or pay for health care services
21 except the following:

22 (a) Long-term care insurance governed by chapter 48.84 RCW;

23 (b) Medicare supplemental health insurance governed by chapter
24 48.66 RCW;

25 (c) Limited health care services offered by limited health care
26 service contractors in accordance with RCW 48.44.035;

27 (d) Disability income;

28 (e) Coverage incidental to a property/casualty liability
29 insurance policy such as automobile personal injury protection
30 coverage and homeowner guest medical;

31 (f) Workers' compensation coverage;

32 (g) Accident only coverage;

33 (h) Specified disease and hospital confinement indemnity when
34 marketed solely as a supplement to a health plan;

35 (i) Employer-sponsored self-funded health plans;

36 (j) Dental only and vision only coverage; and

37 (k) Plans deemed by the insurance commissioner to have a short-
38 term limited purpose or duration, or to be a student-only plan

1 that is guaranteed renewable while the covered person is enrolled
2 as a regular full-time undergraduate or graduate student at an
3 accredited higher education institution, after a written request
4 for such classification by the carrier and subsequent written
5 approval by the insurance commissioner.

6 ((~~(19)~~)) (20) "Material modification" means a change in the
7 actuarial value of the health plan as modified of more than five
8 percent but less than fifteen percent.

9 ((~~(20)~~)) (21) "Preexisting condition" means any medical
10 condition, illness, or injury that existed any time prior to the
11 effective date of coverage.

12 ((~~(21)~~)) (22) "Premium" means all sums charged, received, or
13 deposited by a health carrier as consideration for a health plan
14 or the continuance of a health plan. Any assessment or any
15 "membership," "policy," "contract," "service," or similar fee or
16 charge made by a health carrier in consideration for a health plan
17 is deemed part of the premium. "Premium" shall not include amounts
18 paid as enrollee point-of-service cost-sharing.

19 ((~~(22)~~)) (23) "Review organization" means a disability insurer
20 regulated under chapter 48.20 or 48.21 RCW, health care service
21 contractor as defined in RCW 48.44.010, or health maintenance
22 organization as defined in RCW 48.46.020, and entities affiliated
23 with, under contract with, or acting on behalf of a health carrier
24 to perform a utilization review.

25 ((~~(23)~~)) (24) "Small employer" or "small group" means any
26 person, firm, corporation, partnership, association, political
27 subdivision except school districts, or self-employed individual
28 that is actively engaged in business that, on at least fifty
29 percent of its working days during the preceding calendar quarter,
30 employed no more than fifty eligible employees, with a normal work
31 week of thirty or more hours, the majority of whom were employed
32 within this state, and is not formed primarily for purposes of
33 buying health insurance and in which a bona fide employer-employee
34 relationship exists. In determining the number of eligible
35 employees, companies that are affiliated companies, or that are
36 eligible to file a combined tax return for purposes of taxation by
37 this state, shall be considered an employer. Subsequent to the
38 issuance of a health plan to a small employer and for the purpose

of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

((~~(24)~~)) (25) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(25)~~)) (26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

Sec. 6. RCW 48.43.012 and 2000 c 79 s 19 are each amended to read as follows:

(1) No carrier may reject an individual for an individual health benefit plan based upon preexisting conditions of the individual except as provided in RCW 48.43.018.

(2) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions except as provided in this section.

(3) For an individual health benefit plan originally issued on or after March 23, 2000, preexisting condition waiting periods imposed upon a person enrolling in an individual health benefit plan shall be no more than nine months for a preexisting condition

1 for which medical advice was given, for which a health care
2 provider recommended or provided treatment, or for which a prudent
3 layperson would have sought advice or treatment, within six months
4 prior to the effective date of the plan. No carrier may impose a
5 preexisting condition waiting period on an individual health
6 benefit plan issued to an eligible individual as defined in
7 section 2741(b) of the federal health insurance portability and
8 accountability act of 1996 (42 U.S.C. 300gg-41(b)).
9 (4) Individual health benefit plan preexisting condition
10 waiting periods shall not apply to prenatal care services.
11 (5) No carrier may avoid the requirements of this section
12 through the creation of a new rate classification or the
13 modification of an existing rate classification. A new or changed
14 rate classification will be deemed an attempt to avoid the
15 provisions of this section if the new or changed classification
16 would substantially discourage applications for coverage from
17 individuals who are higher than average health risks. These
18 provisions apply only to individuals who are Washington residents.

19 **Sec. 7.** RCW 48.43.015 and 2000 c 80 s 3 are each amended to read
20 as follows:
21 (1) For a health benefit plan offered to a group other than a
22 small group, every health carrier shall reduce any preexisting
23 condition exclusion or limitation for persons or groups who had
24 similar health coverage under a different health plan at any time
25 during the three-month period immediately preceding the date of
26 application for the new health plan ((~~if such person was~~
27 ~~continuously covered under the immediately preceding health plan.~~
28 ~~If the person was continuously covered for at least three months~~
29 ~~under the immediately preceding health plan,~~)). The carrier may not
30 impose a waiting period for coverage of preexisting conditions((~~.~~
31 ~~If the person was continuously covered for less than three months~~
32 ~~under the immediately preceding health plan~~)) if the aggregate of
33 all periods of preceding coverage, not separated by more than
34 sixty-three days, is at least three months. If the aggregate of all
35 periods of preceding coverage, not separated by more than sixty-
36 three days, is less than three months, the carrier must credit any
37 waiting period under the ((~~immediately~~)) preceding health plan

toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan and plans of the Washington state health insurance pool.

(2) For a health benefit plan offered to a small group, every health carrier shall reduce any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different health plan at any time during the three-month period immediately preceding the date of application for the new health plan ((~~if such person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least nine months under the immediately preceding health plan,~~)). The carrier may not impose a waiting period for coverage of preexisting conditions((~~. If the person was continuously covered for less than nine months under the immediately preceding health plan~~)) if the aggregate of all periods of previous coverage, not separated by more than sixty-three days, is greater than nine months. If the aggregate of all periods of preceding coverage, not separated by more than sixty-three days, is less than nine months, the carrier must credit any waiting period under the ((~~immediately~~)) preceding health plan toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan and plans of the Washington state health insurance pool.

(3) For a health benefit plan offered to an individual, other than an individual to whom subsection (4) of this section applies, every health carrier shall credit any preexisting condition waiting period in that plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new health plan ((~~in a group health benefit plan or an individual health benefit plan, other than a catastrophic health plan~~)), and (a) ((~~the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase; or (b)~~)) the person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state to another

geographic area in Washington state where his or her current health plan is not offered, if application for coverage is made within ninety days of relocation; or ((~~(c)~~)) (b) the person is seeking an individual health benefit plan: (i) Because a health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past twelve months is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan; and (ii) his or her health care provider is part of another carrier's provider network; and (iii) application for a health benefit plan under that carrier's provider network individual coverage is made within ninety days of his or her provider leaving the previous carrier's provider network. ((~~The carrier must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan.~~)) For the person previously enrolled in a group health benefit plan, the carrier must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan or a plan that provided equivalent or greater overall benefit coverage than the coverage the individual seeks to purchase, the carrier must credit the period of coverage the person was continuously covered under the immediately preceding health plan. For the purposes of this subsection (3), a preceding health plan includes an employer-provided self-funded health plan and plans of the Washington state health insurance pool.

(4) Every health carrier shall waive any preexisting condition waiting period in its individual plans for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(5) Subject to the provisions of subsections (1) through (4) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its

1 existing health plans. In addition, nothing in this section
2 requires a carrier to waive benefit limitations not related to an
3 individual or group's preexisting conditions or health history.

4 **Sec. 8.** RCW 48.43.018 and 2000 c 80 s 4 are each amended to read
5 as follows:
6 (1) Except as provided in (a) through (c) of this subsection, a
7 health carrier may require any person applying for an individual
8 health benefit plan to complete the standard health questionnaire
9 designated under chapter 48.41 RCW.
10 (a) If a person is seeking an individual health benefit plan
11 due to his or her change of residence from one geographic area in
12 Washington state to another geographic area in Washington state
13 where his or her current health plan is not offered, completion of
14 the standard health questionnaire shall not be a condition of
15 coverage if application for coverage is made within ninety days of
16 relocation.
17 (b) If a person is seeking an individual health benefit plan:
18 (i) Because a health care provider with whom he or she has an
19 established care relationship and from whom he or she has received
20 treatment within the past twelve months is no longer part of the
21 carrier's provider network under his or her existing Washington
22 individual health benefit plan; and
23 (ii) His or her health care provider is part of another
24 carrier's provider network; and
25 (iii) Application for a health benefit plan under that
26 carrier's provider network individual coverage is made within
27 ninety days of his or her provider leaving the previous carrier's
28 provider network; then completion of the standard health
29 questionnaire shall not be a condition of coverage.
30 (c) If a person is seeking an individual health benefit plan
31 due to his or her having exhausted continuation coverage provided
32 under 29 U.S.C. Sec. 1161 et seq., completion of the standard
33 health questionnaire shall not be a condition of coverage if
34 application for coverage is made within ninety days of exhaustion
35 of continuation coverage. A health carrier shall accept an
36 application without a standard health questionnaire from a person
37 currently covered by such continuation coverage if application is

1 made within ninety days prior to the date the continuation
2 coverage would be exhausted and the effective date of the
3 individual coverage applied for is the date the continuation
4 coverage would be exhausted, or within ninety days thereafter.
5 (2) If, based upon the results of the standard health
6 questionnaire, the person qualifies for coverage under the
7 Washington state health insurance pool, the following shall apply:
8 (a) The carrier may decide not to accept the person's
9 application for enrollment in its individual health benefit plan;
10 and
11 (b) Within fifteen business days of receipt of a completed
12 application, the carrier shall provide written notice of the
13 decision not to accept the person's application for enrollment to
14 both the person and the administrator of the Washington state
15 health insurance pool. The notice to the person shall state that
16 the person is eligible for health insurance provided by the
17 Washington state health insurance pool, and shall include
18 information about the Washington state health insurance pool and
19 an application for such coverage. If the carrier does not provide
20 or postmark such notice within fifteen business days, the
21 application is deemed approved.
22 (3) If the person applying for an individual health benefit
23 plan: (a) Does not qualify for coverage under the Washington state
24 health insurance pool based upon the results of the standard
25 health questionnaire; (b) does qualify for coverage under the
26 Washington state health insurance pool based upon the results of
27 the standard health questionnaire and the carrier elects to accept
28 the person for enrollment; or (c) is not required to complete the
29 standard health questionnaire designated under this chapter under
30 subsection (1)(a) or (b) of this section, the carrier shall accept
31 the person for enrollment if he or she resides within the
32 carrier's service area and provide or assure the provision of all
33 covered services regardless of age, sex, family structure,
34 ethnicity, race, health condition, geographic location, employment
35 status, socioeconomic status, other condition or situation, or the
36 provisions of RCW 49.60.174(2). The commissioner may grant a
37 temporary exemption from this subsection if, upon application by a
38 health carrier, the commissioner finds that the clinical,

financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

Sec. 9. RCW 48.43.025 and 2000 c 79 s 23 are each amended to read as follows:

(1) For group health benefit plans for groups other than small groups, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment((~~, or for which a prudent layperson would have sought advice or treatment,~~)) within three months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(2) For group health benefit plans for small groups, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. Except that a carrier may impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment((~~, or for which a prudent layperson would have sought advice or treatment,~~)) within six months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(3) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the

1 provisions of this section if the new or changed classification
2 would substantially discourage applications for coverage from
3 individuals or groups who are higher than average health risks.
4 These provisions apply only to individuals who are Washington
5 residents.

6 **Sec. 10.** RCW 48.44.017 and 2000 c 79 s 29 are each amended to read
7 as follows:
8 (1) The definitions in this subsection apply throughout this
9 section unless the context clearly requires otherwise.
10 (a) "Claims" means the cost to the health care service
11 contractor of health care services, as defined in RCW 48.43.005,
12 provided to a contract holder or paid to or on behalf of a
13 contract holder in accordance with the terms of a health benefit
14 plan, as defined in RCW 48.43.005. This includes capitation
15 payments or other similar payments made to providers for the
16 purpose of paying for health care services for an enrollee.
17 (b) "Claims reserves" means: (i) The liability for claims which
18 have been reported but not paid; (ii) the liability for claims
19 which have not been reported but which may reasonably be expected;
20 (iii) active life reserves; and (iv) additional claims reserves
21 whether for a specific liability purpose or not.
22 (c) "Earned premiums" means premiums, as defined in RCW
23 48.43.005, plus any rate credits or recoupments less any refunds,
24 for the applicable period, whether received before, during, or
25 after the applicable period.
26 (d) "Incurred claims expense" means claims paid during the
27 applicable period plus any increase, or less any decrease, in the
28 claims reserves.
29 (e) "Loss ratio" means incurred claims expense as a percentage
30 of earned premiums.
31 (f) "Reserves" means: (i) Active life reserves; and (ii)
32 additional reserves whether for a specific liability purpose or
33 not.
34 (2) A health care service contractor shall file, for
35 informational purposes only, a notice of its schedule of rates for
36 its individual contracts with the commissioner prior to use.
37 (3) A health care service contractor shall file with the notice

1 required under subsection (2) of this section supporting
2 documentation of its method of determining the rates charged. The
3 commissioner may request only the following supporting
4 documentation:
5 (a) A description of the health care service contractor's rate-
6 making methodology;
7 (b) An actuarially determined estimate of incurred claims which
8 includes the experience data, assumptions, and justifications of
9 the health care service contractor's projection;
10 (c) The percentage of premium attributable in aggregate for
11 nonclaims expenses used to determine the adjusted community rates
12 charged; and
13 (d) A certification by a member of the American academy of
14 actuaries, or other person approved by the commissioner, that the
15 adjusted community rate charged can be reasonably expected to
16 result in a loss ratio that meets or exceeds the loss ratio
17 standard established in subsection (7) of this section.
18 (4) The commissioner may not disapprove or otherwise impede the
19 implementation of the filed rates.
20 (5) By the last day of May each year any health care service
21 contractor ((~~providing~~)) issuing or renewing individual health
22 benefit plans in this state during the preceding calendar year
23 shall file for review by the commissioner supporting documentation
24 of its actual loss ratio for its individual health benefit plans
25 offered or renewed in this state in aggregate for the preceding
26 calendar year. The filing shall include aggregate earned premiums,
27 aggregate incurred claims, and a certification by a member of the
28 American academy of actuaries, or other person approved by the
29 commissioner, that the actual loss ratio has been calculated in
30 accordance with accepted actuarial principles.
31 (a) At the expiration of a thirty-day period beginning with the
32 date the filing is ((~~delivered to~~)) received by the commissioner,
33 the filing shall be deemed approved unless prior thereto the
34 commissioner contests the calculation of the actual loss ratio.
35 (b) If the commissioner contests the calculation of the actual
36 loss ratio, the commissioner shall state in writing the grounds
37 for contesting the calculation to the health care service
38 contractor.

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health care service contractor be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) of this section, a remittance is due and the following shall apply:

(a) The health care service contractor shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest shall be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) The loss ratio applicable to this section shall be seventy-four percent minus the premium tax rate applicable to the health care service contractor's individual health benefit plans under RCW 48.14.0201.

Sec. 11. RCW 48.46.062 and 2000 c 79 s 32 are each amended to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health maintenance organization of health care services, as defined in RCW 48.43.005,

1 provided to an enrollee or paid to or on behalf of the enrollee in
2 accordance with the terms of a health benefit plan, as defined in
3 RCW 48.43.005. This includes capitation payments or other similar
4 payments made to providers for the purpose of paying for health
5 care services for an enrollee.
6 (b) "Claims reserves" means: (i) The liability for claims which
7 have been reported but not paid; (ii) the liability for claims
8 which have not been reported but which may reasonably be expected;
9 (iii) active life reserves; and (iv) additional claims reserves
10 whether for a specific liability purpose or not.
11 (c) "Earned premiums" means premiums, as defined in RCW
12 48.43.005, plus any rate credits or recoupments less any refunds,
13 for the applicable period, whether received before, during, or
14 after the applicable period.
15 (d) "Incurred claims expense" means claims paid during the
16 applicable period plus any increase, or less any decrease, in the
17 claims reserves.
18 (e) "Loss ratio" means incurred claims expense as a percentage
19 of earned premiums.
20 (f) "Reserves" means: (i) Active life reserves; and (ii)
21 additional reserves whether for a specific liability purpose or
22 not.
23 (2) A health maintenance organization shall file, for
24 informational purposes only, a notice of its schedule of rates for
25 its individual agreements with the commissioner prior to use.
26 (3) A health maintenance organization shall file with the
27 notice required under subsection (2) of this section supporting
28 documentation of its method of determining the rates charged. The
29 commissioner may request only the following supporting
30 documentation:
31 (a) A description of the health maintenance organization's rate-
32 making methodology;
33 (b) An actuarially determined estimate of incurred claims which
34 includes the experience data, assumptions, and justifications of
35 the health maintenance organization's projection;
36 (c) The percentage of premium attributable in aggregate for
37 nonclaims expenses used to determine the adjusted community rates
38 charged; and

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

(5) By the last day of May each year any health maintenance organization ((~~providing~~)) issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in the state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is ((~~delivered to~~)) received by the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health maintenance organization.

(c) Any dispute regarding the calculation of the actual loss ratio shall, upon written demand of either the commissioner or the health maintenance organization, be submitted to hearing under chapters 48.04 and 34.05 RCW.

(6) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (7) of this section, a remittance is due and the following shall apply:

(a) The health maintenance organization shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

1 (b) The remittance to the Washington state health insurance
2 pool is the percentage calculated in (a) of this subsection,
3 multiplied by the premium earned from each enrollee in the
4 previous calendar year. Interest shall be added to the remittance
5 due at a five percent annual rate calculated from the end of the
6 calendar year for which the remittance is due to the date the
7 remittance is made.
8 (c) All remittances shall be aggregated and such amounts shall
9 be remitted to the Washington state high risk pool to be used as
10 directed by the pool board of directors.
11 (d) Any remittance required to be issued under this section
12 shall be issued within thirty days after the actual loss ratio is
13 deemed approved under subsection (5)(a) of this section or the
14 determination by an administrative law judge under subsection
15 (5)(c) of this section.
16 (7) The loss ratio applicable to this section shall be seventy-
17 four percent minus the premium tax rate applicable to the health
18 maintenance organization's individual health benefit plans under
19 RCW 48.14.0201.

20 **Sec. 12.** RCW 70.47.060 and 2000 c 79 s 34 are each amended to read
21 as follows:
22 The administrator has the following powers and duties:
23 (1) To design and from time to time revise a schedule of
24 covered basic health care services, including physician services,
25 inpatient and outpatient hospital services, prescription drugs and
26 medications, and other services that may be necessary for basic
27 health care. In addition, the administrator may, to the extent that
28 funds are available, offer as basic health plan services chemical
29 dependency services, mental health services and organ transplant
30 services; however, no one service or any combination of these
31 three services shall increase the actuarial value of the basic
32 health plan benefits by more than five percent excluding
33 inflation, as determined by the office of financial management.
34 All subsidized and nonsubsidized enrollees in any participating
35 managed health care system under the Washington basic health plan
36 shall be entitled to receive covered basic health care services in
37 return for premium payments to the plan. The schedule of services

1 shall emphasize proven preventive and primary health care and
2 shall include all services necessary for prenatal, postnatal, and
3 well-child care. However, with respect to coverage for subsidized
4 enrollees who are eligible to receive prenatal and postnatal
5 services through the medical assistance program under chapter
6 74.09 RCW, the administrator shall not contract for such services
7 except to the extent that such services are necessary over not
8 more than a one-month period in order to maintain continuity of
9 care after diagnosis of pregnancy by the managed care provider.
10 The schedule of services shall also include a separate schedule of
11 basic health care services for children, eighteen years of age and
12 younger, for those subsidized or nonsubsidized enrollees who
13 choose to secure basic coverage through the plan only for their
14 dependent children. In designing and revising the schedule of
15 services, the administrator shall consider the guidelines for
16 assessing health services under the mandated benefits act of 1984,
17 RCW 48.47.030, and such other factors as the administrator deems
18 appropriate.
19 (2)(a) To design and implement a structure of periodic premiums
20 due the administrator from subsidized enrollees that is based upon
21 gross family income, giving appropriate consideration to family
22 size and the ages of all family members. The enrollment of children
23 shall not require the enrollment of their parent or parents who
24 are eligible for the plan. The structure of periodic premiums shall
25 be applied to subsidized enrollees entering the plan as
26 individuals pursuant to subsection (9) of this section and to the
27 share of the cost of the plan due from subsidized enrollees
28 entering the plan as employees pursuant to subsection (10) of this
29 section.
30 (b) To determine the periodic premiums due the administrator
31 from nonsubsidized enrollees. Premiums due from nonsubsidized
32 enrollees shall be in an amount equal to the cost charged by the
33 managed health care system provider to the state for the plan plus
34 the administrative cost of providing the plan to those enrollees
35 and the premium tax under RCW 48.14.0201.
36 (c) An employer or other financial sponsor may, with the prior
37 approval of the administrator, pay the premium, rate, or any other

amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator.

(d) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, 2001, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

(3) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized and nonsubsidized enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists.

(5) To limit the payment of subsidies to subsidized enrollees, as defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(6) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan for either subsidized enrollees, or nonsubsidized enrollees, or both. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health

care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(8) To receive periodic premiums from or on behalf of subsidized and nonsubsidized enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a

1 recipient of medical assistance or medical care services under
2 chapter 74.09 RCW. If a number of enrollees drop their enrollment
3 for no apparent good cause, the administrator may establish
4 appropriate rules or requirements that are applicable to such
5 individuals before they will be allowed to reenroll in the plan.
6 (10) To accept applications from business owners on behalf of
7 themselves and their employees, spouses, and dependent children,
8 as subsidized or nonsubsidized enrollees, who reside in an area
9 served by the plan. The administrator may require all or the
10 substantial majority of the eligible employees of such businesses
11 to enroll in the plan and establish those procedures necessary to
12 facilitate the orderly enrollment of groups in the plan and into a
13 managed health care system. The administrator may require that a
14 business owner pay at least an amount equal to what the employee
15 pays after the state pays its portion of the subsidized premium
16 cost of the plan on behalf of each employee enrolled in the plan.
17 Enrollment is limited to those not eligible for medicare who wish
18 to enroll in the plan and choose to obtain the basic health care
19 coverage and services from a managed care system participating in
20 the plan. The administrator shall adjust the amount determined to
21 be due on behalf of or from all such enrollees whenever the amount
22 negotiated by the administrator with the participating managed
23 health care system or systems is modified or the administrative
24 cost of providing the plan to such enrollees changes.
25 (11) To determine the rate to be paid to each participating
26 managed health care system in return for the provision of covered
27 basic health care services to enrollees in the system. Although the
28 schedule of covered basic health care services will be the same or
29 actuarially equivalent for similar enrollees, the rates negotiated
30 with participating managed health care systems may vary among the
31 systems. In negotiating rates with participating systems, the
32 administrator shall consider the characteristics of the
33 populations served by the respective systems, economic
34 circumstances of the local area, the need to conserve the
35 resources of the basic health plan trust account, and other
36 factors the administrator finds relevant.
37 (12) To monitor the provision of covered services to enrollees
38 by participating managed health care systems in order to assure

enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(13) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(14) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(15) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

(16) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

(17) To administer the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington state health insurance pool.

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